

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008661-  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2451**

VS 300  
Rev. 4/59

1

2 **205**

3

4 **2**

5 **0**

6

7 **0**

8 **1**

9

10

11

12 **90-3**

13

**90**

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

|  |   |  |                                    |
|--|---|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>FILED MAR 14 1963</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY  |                                    |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>MO St Louis</b>  |   | c. CITY OR TOWN <b>St Louis</b>  |                                    |
| Length of stay in 1b<br><b>3 mo</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>6066 Cates</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>6066 Cates</b>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print) <b>Charles</b> First <b>Goode</b> Last <b>JR.</b>   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>1</b> Year <b>63</b>   |                                    |
| 5. SEX <b>M.</b>   | 6. COLOR OR RACE <b>NEGRO.</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>             | 8. DATE OF BIRTH <b>11-21-1962</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |                                    |
| 11. BIRTHPLACE (City and state or country)<br><b>St Louis</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>  |                                    |
| 13a. FATHER'S NAME<br><b>Charles Goode SR.</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sally Goode</b>  |                                    |
| 14. NAME OF HUSBAND OR WIFE<br><b>NONE</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>NO</b>  |                                    |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT<br>Name <b>Charles Goode</b> Address <b>6066 Cates</b>   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Interstitial Pneumonia</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>492x</b><br>DUE TO (c) |   | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                    |
| 20c. TIME OF INJURY<br>Hour <b>4:05 A</b> Month, Day, Year <b>3-5-63</b>   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |                                    |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION<br><b>St Louis</b> COUNTY <b>MO</b> STATE <b>MO</b>   |                                    |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.<br>Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.   |   |  |                                    |
| 22a. SIGNATURE<br><b>Franklin D. Price</b> (Degree or title)   |   | 22b. ADDRESS<br><b>1300 Clark</b>  |                                    |
| 22c. DATE SIGNED<br><b>3-2-63</b>  |   | 23. NAME OF CEMETERY OR CREMATORY<br><b>St Louis 40. mo</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>PRICE UNCO</b> ADDRESS <b>2829 Washington</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 4 1963</b>  |                                    |
| 26. REGISTRAR'S SIGNATURE<br><b>Franklin D. Price</b>  |   | 27. REGISTRAR'S SIGNATURE<br><b>Franklin D. Price</b>  |                                    |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Edward A. Flynn*

Licensed Embalmer No. *4444*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.